CHAPTER 7

A brief history of mental disorder

Chapter contents

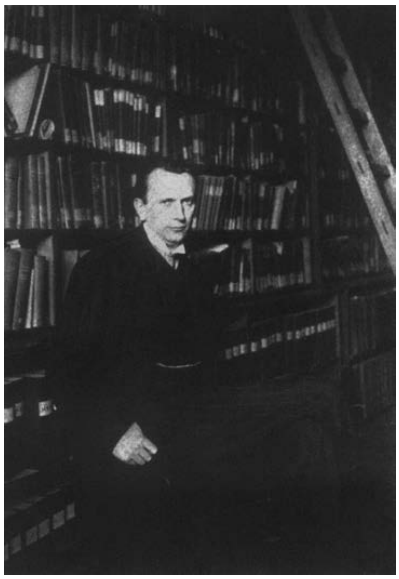

Fig. II.3 Jaspers as a young man in the library of the Department of Psychiatry in the University of Heidelberg.

There are many in psychiatry, and in other mental health disciplines, who see the history of early twentieth century psychiatry, not as a guide to the paradigm shifts we now face, but as a record of psychiatry's paradigms finally reaching a settled state. Those responsible, in particular, for the development of our modern classifications of mental disorders, the ICD and DSM, have often appeared to take this view of our history.

We touched on these classifications at various points in Part I and we will be returning to them in more detail in Part III. As we will see, they have played a vital role in the descriptive groundwork necessary for the application of modern neuroscience to mental disorders, and hence for the changes of paradigm which this is likely to catalyse. However, the architects of these classifications have too often seen themselves not so much as catalysts as crystallizers. They have seen their role as settling once and for all the theoretical tools for shaping our diagnostic concepts. Future researchers, according to this view, will provide new data: but how we organize the data, what indeed counts as data, they take to be largely settled.

This could be right. The history of science itself, though, makes it unlikely, for predictions of the 'end of history' in science have always been falsified, and not least in that hardest of hard sciences, physics. At the end of the nineteenth century, many physicists believed their theoretical paradigms were largely settled—yet within 20 years, they had relativity theory and quantum mechanics! Whether psychiatry will produce its Einstein or Heisenberg, whether we have a twenty-first century Karl Jaspers perhaps already working on his or her PhD, only time will tell. If history is any guide, she or he will have trouble with the examiners!

This chapter and this part of the book

In this chapter, then, we will be taking a whistle-stop tour through a two and a half thousand year history of ideas about mental disorder. This will be by way of preparation for a closer study of Karl Jaspers' work in Chapter 8, and of the main philosophical sources of his psychopathology in Chapters 9 and 10. To understand Jaspers' work on psychopathology, however, we need to understand the problem he was tackling: and to understand Jaspers' problem, we need to understand its historical context. This is why this chapter will be taken up with a few basic facts about the history of psychiatry, focusing particularly on the way mental disorders have been understood at different historical periods.

Session 1 Introduction and overview

Facts and fictions

'Facts' in history, even 'basic facts', are notoriously elusive. The historical record is always incomplete; and such records as there are always have to be interpreted. The difficulties of interpretation, moreover, are compounded for the history of *ideas* by the problems of translation: from one language to another; from one culture to another. And to all these difficulties, when it comes to the history of ideas in *psychiatry*, we have to add the fact that the relevant ideas—rationality, reason, responsibility, and so forth—are themselves complex and difficult to understand.

Few have made a greater individual contribution to assembling the facts, such as they are, of the development of our psychopathological concepts than the Cambridge historian and psychiatrist, German Berrios. As a philosopher as well as historian, few have been as aware as Berrios of the methodological and conceptual pitfalls of work in this area. In our first reading, Berrios sets out some of these issues.

EXERCISE 1 (30 minutes)

Read the extract from:

Berrios, G.E. (1996). Matters historical. *The History of Mental Symptoms. Descriptive psychopathology since the nineteenth century*. Cambridge: Cambridge University Press, p. 7

Link with Reading 7.1

- Note the different ways in which some of the founders of modern psychiatry used historical sources.

Together with a companion volume, *History of Clinical Psychiatry*: *the origin and history of psychiatric disorders* (co-edited with Roy Porter, 1995), Berrios' *The History of Mental Symptoms* provides an invaluable resource for work on the history of psychopathology.

In the introductory section from which the extract linked with Exercise 1 is taken, Berrios notes the wide variety of approaches to psychiatric history, ranging from Haslam, who was interested in 'historical semantics', to Pinel, who regarded history as a record of past failures against which the triumph of 'the modern' should be contrasted. These and other approaches are complementary, illuminating practice in different ways. Yet history, like science, has been 'post-modernised' (not Berrios' term!). In place of the 'Whiggish' march-of-progress view, we now have a more cautious, piecemeal, and perspectival model. Traditionally, the history of medicine has seen itself somewhat like a science, discovering the truth. Current history of psychiatry is understood more on the model of a sculptor, carving out a story. Which model we opt for in the history of psychopathology, Berrios goes on to argue, should be determined by which is 'more suitable to [our] own beliefs and the symptom under study' (p. 11).

If Berrios is right, then, it is small wonder that the history of psychiatry, let alone the history of the concept of mental illness, has been given widely different 'spins' by different authors. This is not in itself a bad thing. If different authors have different interpretations, this can deepen understanding. If the historical record is explained in different ways, this can increase the resources for philosophical and other studies. We will be looking at some aspects of all this later in this session. But it is, none the less,

important to be aware of the 'spins'. If history is a guide, historians may guide us in different directions!

The rest of this chapter

With these caveats, we will start with an outline of how psychiatry has developed. This will help us to locate Karl Jaspers in the history of the subject. As we will see, his seminal work on psychopathology in the early years of the twentieth century, rides on the back of a history, spanning two and a half millennia, of attempts to make sense of madness.

One 'spin' on this history, as a history of ideas, is that it reflects a continuing tension, oscillating sometimes one way and sometimes the other, between moral and natural conceptions of mental disorder. This is illustrated diagrammatically in Figure 7.1. As this shows, the modern debate, outlined in Chapters 2, 4, and 6, between antipsychiatry (moral) and psychiatry (natural), including

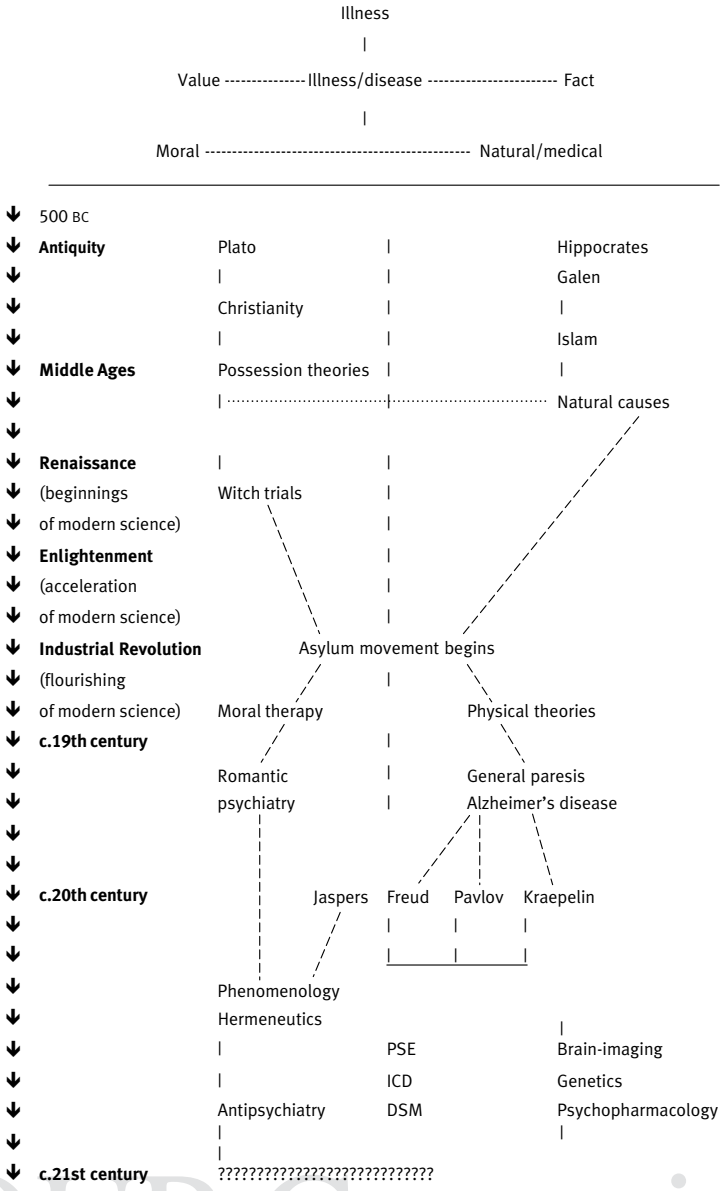

Fig. 7.1 Flow diagram of a conceptual history of mental disorder.

their different 'takes' on the roles of facts and values in the definitions of psychopathological concepts, is but the latest manifestation of this historical tension. Our understanding of mental disorder (or madness) has oscillated between the two extremes over at least two and a half millennia.

We will start with an overview of this history of moral and medical interpretations before considering each of its stages in a little more detail.

A history of mental disorder in twenty minutes

Ideas about mental disorder, as we should expect, follow the spirit of the times. The history of madness can thus be divided up broadly by historical periods.

- *The Classical Period* (from before 500 BC to AD c.500). The split between moral and natural conceptions of madness was well established by the time of Plato and Hippocrates in the fifth and fourth centuries BC. Plato's 'harmony of the soul' conception of mental health was (as now) scoffed at by the medics of the day, who subscribed to Hippocrates' 'harmony of the humours' conception (which owed more to Aristotelian physiology). A similar division is evident in later Roman thought, between the Stoics (moral conceptions) and the counterpart to Hippocrates, Galen (medical conceptions).
- *The Middle Ages* (c.500–1500). In the early Medieval period (also called the Dark Ages) the moral conception, under the influence of Christianity, was dominant particularly in the Western Empire, in the form of possession theories of madness. In Islamic countries, by contrast, the natural causes (medical) conception of Hippocrates and Galen continued to be the dominant theory; and this theory staged a comeback even in western Europe in the later Middle Ages.
- *Renaissance and Reformation* (c.1450–1700). This was the period of the 'witch panics' in Europe. Fired by competing ideologies of Catholic and Protestant, the possession theory of madness led to the torture and execution of many mentally disordered people—and note the paradox that this was also the period of Renaissance science (e.g. Bacon, Galileo, Copernicus).
- *Enlightenment* (c.1700–1800). Partly in revulsion at the religious excesses of the witch trials, the Enlightenment saw a reassertion of natural cause theories of madness. Combined with the humanitarian spirit of the age, this was the period when provision of 'asylum' for people with mental disorders first became widely available, initially in the form of private 'mad houses', later with the establishment of the first large public asylums.
- *The Great Confinement* (c.1750–1850). As the Industrial Revolution gathered pace, the numbers admitted to institutional care rose sharply. The nature of the causal relationship here remains the subject of lively historical debate. Whatever the case, for reasons partly of private greed, partly of lack of public resources, conditions in many 'mad houses' were appalling. And the fate of those committed was compounded by 'medical' theories that favoured restraint and other punitive treatments, such as ducking and spinning. It was against such abuses that the great reformers at the turn of the nineteenth century (Pinel and Esquirol in France; Samuel Tuke and John Connolly in England) sought to establish more humane regimes based on what came to be called 'moral therapies'.
- *The first biological phase* (c.1850–1910). The nineteenth century, though, was also the century of scientific medical advance; it saw the first localizations of cerebral function, the establishment of university clinics for psychiatry, notably in Germany, and, by the early years of the twentieth century, the identification of two organic mental disorders, general paralysis (syphilis of the brain) and Alzheimer's disease. In the UK, the Royal Medico-Psychological Association, from which the Royal College of Psychiatrists is descended, was established in 1841. With the growing authority of their profession, it was natural that doctors should be increasingly appointed as superintendents of county and private asylums, thus giving them ample opportunity to study the psychopathology of mental disorders.
- *The turn of the twentieth century*. Enthusiasm for biological psychiatry, combined with the availability of 'clinical material', led to a proliferation of classifications of mental disorders in the second half of the nineteenth century. From this, Kraepelin, Bleuler, and others, established the main outlines of our current classifications. This was also Karl Jaspers' time. Commissioned to write a textbook on psychopathology, he dug deep into the philosophical foundations of psychiatry, producing his *Allgemeine Psychopathologie* (*General Psychopathology*) in 1913.
- *A twin-track twentieth century* (c.1900–1980). An important theme of *General Psychopathology*, and of all Jaspers' work, was the need for meaningful as well as causal explanations of mental disorder. Through most of the twentieth century, though, 'causal' and 'meaningful' have followed largely separate tracks. Jaspers, it must be emphasized, rejected Freud, and vice versa; and Freud conceived psychoanalysis, at least in its early days, as an extension of medical psychology and neuroscience. None the less, it is Freud, and the psychoanalytic movement, together with the phenomenologists, who have focused on meanings (psychoanalysis, as we saw in Chapter 4, was interpreted by the French philosopher Paul Ricoeur, as a kind of hermeneutics of the mind), while the rest of medical psychiatry has focused on causes. As we will see, both approaches, the one via meanings and the other via causes, have been hugely successful, albeit in different parts of the world and in different ways.
- *The second biological phase* (c.1980 to today): As we approached the end of the twentieth century, biological psychiatry was once again in the ascendant. The 1990s were indeed heralded as the decade of the brain. As at the end of the nineteenth century, this renewed ascendance of the medical model was science driven—the new genetics, brain imaging, and psychopharmacology

were the inspirations for late twentieth century biological psychiatry, just as neuroanatomy, differential histological stains and germ theory were the inspirations for late nineteenth century biological psychiatry.

Such is the 'march' of history, then! But what will follow? What will future histories of psychiatry add retrospectively. For besides intriguing similarities, there are also important differences between the state of psychiatry now and its state at the end of the nineteenth century. We will return to these later. But a key difference is the state of our classifications of mental disorders. At the end of the nineteenth century there was 'diagnostic anarchy'; at the end of the twentieth century we have, at least within medicine, a broadly agreed outline of a classification of mental disorders to serve as the descriptive springboard for the causal theories promised by the new neurosciences.

As already noted, it is to Jaspers (among others) that we owe the psychopathological theories on which these classifications are based. We will return to Jaspers' psychopathology in Chapter 8. First, though, in the remainder of this chapter, we will take a more detailed look at some of the key stages in the development of psychiatry.

Reflection on the session and self-test questions

Write down your own reflections on the materials in this session drawing out any points that are particularly significant for you. Then write brief notes about the following:

1. How far back does the concept of mental illness (broadly understood) go?
2. What is the historical relationship between medical-scientific and moral-humanistic models of 'madness'?

Session 2 The main historical periods

The Classical period

The Greeks had a word for it

Most histories of 'madness' start with the Greeks. Interpreting how such a complex notion was understood over 2000 years ago, raises all the key problems noted above of historical analysis of ideas! But 'madness' was certainly recognized in one form or other in Classical times, it was subject to competing causal theories (including a link with disease), and it had many of its present-day moral and legal connotations.

The American philosopher and psychologist, Daniel Robinson, to whose remarkable history of the insanity defence we return below (Robinson, 1996), points (slightly tongue in cheek) to the earliest record of a successful defence on grounds of madness in Homer's epic poem, the *Iliad*. The warring parties in the Trojan wars having fought each other to a standstill, King Agamemnon seeks to excuse his original provocative actions, 'It was not I that did it' he says, 'Zeus and Fate, the erinys that walk in darkness struck me mad when we were assembled on the day that I took from Achilles the prize that had been awarded him . . .'. Similarly, in Book IV of the Odyssey, Helen excuses her original abandonment of hearth and home as 'the madness that Aphrodite bestowed when she led me here' (pp. 8–9).

It is with Plato, though, a few centuries later, and at the height of Classical Greek culture, that we find one of the first recognizably modern accounts of mental health. Our next reading is taken from a classic paper on Plato's conception of mental disorder by the Oxford philosopher, Anthony (A.J.P.) Kenny.

EXERCISE 2 (60 minutes)

Read the opening passage from:

Kenny, A.J.P. (1969). Mental health in Plato's *Republic*. *Proceedings of the British Academy* (3.12.1969), pages 229–253

Link with Reading 7.2

Note the strikingly confident assertion with which Kenny opens his article, that 'The concept of mental health was Plato's invention'; however:

1. In which of Plato's books does Kenny identify the first non-metaphysical use of the concept of mental health?
2. What competing' models' were there in Classical Greece?

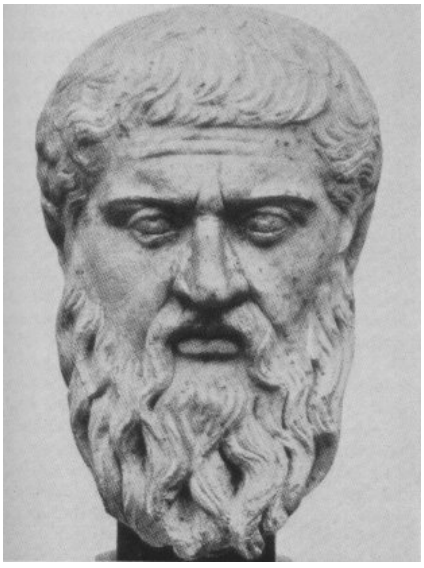

Fig. 7.2 Plato

Like Robinson, Kenny notes many early examples of the use of medical metaphors; but it is with the Plato of *The Republic*, he suggests, that we find for the first time a genuine theory of madness as a sickness or disease of the mind. In the rest of this article, Kenny goes on to describe how the standard 'medical' model of the time (i.e. of Hippocrates and, in later Roman medicine, of Galen) was of a balance or harmony of the elements of the constitution (Kenny notes the Galenic 'wet, hot, dry, cold, sour and sweet', p. 231). Plato, he suggests, applied this model to 'disorders of the soul' (p. 231), identifying, with some variation, three constituents of the soul, reason, appetite, and temper. Reason, aided by temper, rules appetite. There are shades of Freud here, as Kenny notes (p. 238 et seq.). By the start of section V, though, Kenny is clear that Plato, although developing what appears to be a *moral* concept of mental health, is intent on assimilating the moral to a *medical* model. He (Kenny) deplores this attempted assimilation, identifying a similar move underpinning modern attitudes to mental disorder (notably in the Mental Health Act, 1959, the legislation in force at the time in the UK governing issues such as involuntary treatment). Reacting against the assimilation of morals to medicine, as many others have done, Kenny identifies with an overtly medical model: 'In the paradigmatic cases of mental illness (e.g. schizophrenia)', he says, 'organic causes are known or suspected'. Hippocrates and Galen would have approved!

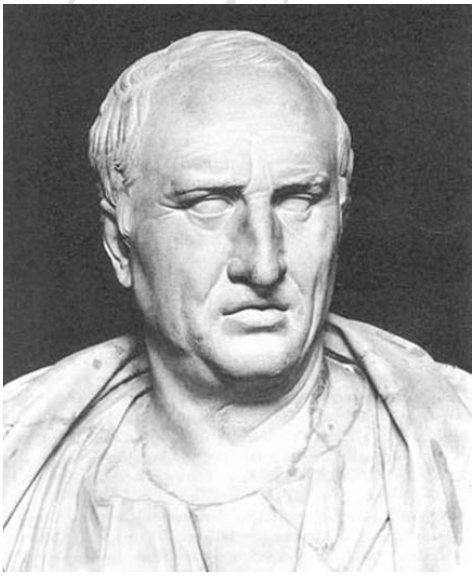

Fig. 7.3 Cicero

Roman stoicism

Some of the difficulties of translating Classical conceptions into a modern context are illustrated by a debate in *Philosophy, Psychiatry and Psychology* around an article by the Swedish philosopher, Lennart Nordenfelt, on Stoic conceptions of mental health. Nordenfelt, as we noted in Chapter 6, Reading Guide, has made important contributions to the literature on the concept of health, exploring in particular the links between agency and health (see, e.g. Nordenfelt, 1987). However, in this article he is concerned rather with the parallels between Stoic and present day conceptions of mental health.

EXERCISE 3 (60 minutes)

Read the extract from:

Nordenfelt, L. (1997a). The stoic conception of mental disorder: the case of Cicero. *Philosophy, Psychiatry and Psychology*, 4, 285–291. (Extract 287–288.)

Link with Reading 7.3

Note also the commentaries by Blackburn (pp. 293–294), Leavy (pp. 295–296), Mordini (pp. 297–302), and Rhodes (pp. 303–304); and Nordenfelt's response (1997b, pp. 305–306) in *Philosophy, Psychiatry and Psychology*.

- How far do you think the Stoic ideas on mental health outlined by Nordenfelt in this extract parallel modern models?

In the passage preceding this extract, Nordenfelt describes (p. 286) how Stoic philosophy was 'material, deterministic but at the same time teleological', i.e. in the sense that the course of the world is guided by '*Logos* or *God*... for the good of human beings'. We should thus 'meet every event with a sense of security or independence'. This 'apatheia' is the basis of what Nordenfelt claims is a Stoic theory of mental health (p. 286). This theory, as he spells out in this extract, can be identified as being developed into a Stoic classification of mental disorders not entirely unlike our modern classifications. He emphasizes that the analogy should not be pushed too far: 'apatheia' itself, at the heart of Stoic philosophy, has no obvious parallel in modern mental health; and we should certainly not want to go as far as Cicero in regarding extremes of emotion as necessarily disordered! But as to the practical implications of the theory, as to what it implies for how we should *achieve* mental health, there are clear parallels, he concludes later in the paper, with modern cognitive-behavioural approaches. Again, the analogy should not be pressed too far. But the 'nub' of Nordenfelt's paper is the essentially modern point that values, 'ideas about the good and virtuous man', are inextricably intertwined with ideas about mental health (p. 290).

The commentators on Nordenfelt's challenging claims represented a range of very different views. At one extreme, Rosamund Rhodes (1997), a Classical scholar and bioethicist working at The Mount Sinai Hospital, New York, argued for a reading of Stoic philosophy different from Nordenfelt's. At the other extreme, Ivy Blackburn (1997), also a Classical scholar but now a Professor of Clinical Psychology, largely endorsed Nordenfelt's reading, in particular what she called the 'fudge' of mental health and

virtue. Stan Leavy (1997), a physician, took from all this, the necessity, the *human* necessity, of retaining some notion of radical freedom, of the reality of choice. Emilio Mordini (1997), a psychiatrist and psychoanalyst (and a Classical scholar) working in Rome, also largely endorsed Nordenfelt's reading; but, locating Stoic philosophy firmly in its cultural and historical context, he noted the extent to which modern philosophy and neuroscience are undermining the traditional separation of reason and emotion.

Reactions to the paper and the ensuing discussion varied widely! Of course, there can be no final answer as to whether Nordenfelt is right or not. In the first place, scholars of equal eminence may 'read' the Stoics differently (Rhodes, for example, clearly read them differently from Nordenfelt and Blackburn). But these different readings are in different ways enlightening. These papers thus illustrate the richness of resources offered by Classical attempts to understand mental distress and disorder. We may end up either for or against a particular point of view, or in some more complex mixture of points for and against, or with a distinct view of our own. The message, though, is in what we learn from the debate itself.

The Middle Ages and beyond

Medieval madness

In the early Middle Ages, as we noted above, attitudes to the insane were very different in the Islamic and (Western) Christian worlds. The Islamic world, influenced by the medical and physiological works of Hippocrates and Galen, continued to regard madness as largely a product of brain disease. In the Christian world, although there were many who subscribed to 'brain' theories, the dominant aetiological theory was of possession by demons. It was this theory that, in the late Middle Ages, as the Church sought increasingly desperately to eradicate heresy, led to the mentally ill sometimes being tried as witches.

The gradual dominance of Christian (moral) conceptions of madness over late Roman (natural causes) theories is graphically charted by Daniel Robinson in his *Wild Beasts and Idle Humours* (from which we quoted above).

EXERCISE 4 (20 minutes)

Read the extract from:

Robinson, D. (1996). Immortal souls, mortal cities. Chapter 2 in *Wild Beasts and Idle Humours: the insanity defense from antiquity to the present*. Cambridge, MA: Harvard University Press, pp. 55–56

Link with Reading 7.4

Robinson summarizes in this section how Christian notions of sin and possession came to overlay and largely displace Classical natural-causes notions of mental disorder. However, witch trials were not to become widespread until a later period.

- Why do you think this was?
- Why the delay?

On a separate point, do you see any particular advantages for the history of ideas in studying legal history?

Robinson's book is a scholarly but highly readable history of the insanity defence. He notes in the 'Introduction' (p. 2) that a legal history of insanity has the great advantage for the 'history of ideas' that the law does not have the luxury of idle speculation, but has to dispose of real cases. The history of legal insanity thus provides a valuable 'probe' to the *zeitgeist* on mental disorders of different periods. There is a nice link here, then, with J. L. Austin's comments on the merits of legal cases as a resource for ordinary language philosophy (see especially Chapter 4).

In the section of his book from which this extract is taken, Robinson describes how, despite the rise of Christian ideology, the Middle Ages were not a time of particular persecution of the 'mad'. True, like physical diseases, madness was believed at this time to be often the result of possession. But this was not in itself a matter for persecution. The seeds of later persecution were there, of course; but in the Middle Ages, at least in western Europe, the prevailing ideology was too secure to fear deviance. As we will see shortly it was only with the Reformation that it became increasingly necessary to persecute 'heretics'.

In the late Medieval period, there was a strong revival of Aristotelian naturalistic doctrines. St Thomas Aquinas, for example, seems to have regarded at least many forms of insanity as natural in origin; he recognized different kinds of mental disorder (distinguishing congenital and non-congenital forms, for example); and appears to have regarded the insane as irrational and hence as lacking the capacity for sin. The law, similarly, while seeking to protect society, provided for the insane to be released into the care of their family once they were no longer considered dangerous. There was also a degree of institutional care: a notable example was the hospice established by the Priory of St Mary of Bethlehem in 1403 specifically for the insane. It started with six male patients, and remains with us today in the form of the Maudsley and Bethlem Hospitals in South London. (The original name 'Bethlehem' was shortened to 'Bethlem' from which the corruption 'Bedlam' is derived.) In this period, then, while demon-possession remained a popular 'folk' theory, the official doctrines of Church and State were largely humanistic.

Satan and Renaissance science

The Renaissance period right through to the end of the eighteenth century, was marked by a tension between scientific and satanic explanations of mental disorder. It is important to note the paradox that, even as natural science was becoming ever more successful, demonology, witch-hunts, and the torture and execution of many mentally ill people as witches, reached epidemic proportions.

The cultural environment that fostered the witch trials was the long-running battle between Catholic and Protestant. The Reformation forced the Catholic Church into ever more frenzied attempts to root out heresy. The Counter-Reformation prompted the Protestants to equally frenzied attempts to demonstrate that God was with them. Witches were an easy target for both; and people with severe mental illness, whose psychopathology of course often included delusions of guilt, of satanic possession, and so on, were a ready source of 'witches'. But natural science and medicine were often partners in the witch trials, offering 'expert' evidence, including specific signs such as a third nipple and pain-insensitive areas.

The next reading (see Exercise 5), which is from a major 'text-book' for witch-prickers of the day, the notorious *Malleus Maleficarum* (Kramer and Sprenger, 1996), shows just how easy it was for science to end up as a partner to religion in this way.

EXERCISE 5 (45 minutes)

Read the three extracts from:

Kramer, H and Sprenger, J. (1996). Malleus Maleficarum (The Witch Hammer). Published as *Malleus Maleficarum*: *the Classic Study of Witchcraft*, translated with an introduction, bibliography, and notes, by Montague Summers. London: Bracken Books, pp. 211, 213, and 227

Link with Reading 7.5

Heinrich Kramer and James Sprenger were two Dominican monks working as Inquisitors in northern Germany in the late fifteenth century. Their book is a detailed and scholarly work, adamant in its opposition to witchcraft, but spelling out meticulous rules of procedure aimed at avoiding the innocent being falsely convicted.

- How successful do you think Kramer and Sprenger were in this, however?
- As you read the extracts, identify the 'proofs' they offer of witchcraft, and note any modern parallels to the procedures they advocate.

Published with a preface in the form of a Papal Bull from Innocent VIII (1484), the *Malleus Maleficarum* rapidly became the most widely read and respected authority on witchcraft. It is impressive in its detailed treatment of every aspect of the identification, prosecution, and disposal of suspects.

From our perspective, the 'proofs' it offers may seem naïve. But if you believe in witchcraft, then the 'proofs' are little different in form from those offered in modern contexts. Thus, in the first extract (p. 211) they set out what in a modern textbook of medicine we would call the 'history of the presenting complaint'. In the second extract (p. 213), they note that a 'diagnosis' (not their word) should be based on: (1) the bad reputation of the accused; (2) evidence of the 'fact'; and (3) the words of witnesses. Well, as to (1), it is still true that we say 'give a dog a bad name . . .', and 'no smoke without fire'. As to (2), evidence of the fact is a Humean 'constant conjunction' theory of causality—the accused touched a child, and it fell sick; the accused was seen looking at her neighbour's cows, and the milk yield fell; she was in the field when the tempest blew up, etc. And as to (3), about witnesses, while Kramer and Sprenger are clear about the danger of false witness, if sufficient 'good men and true' give evidence, then it must be so—an early, and still persisting emphasis on operationalism in psychopathological diagnosis.

There are even objective signs of witchcraft. On p. 227, for example, in the third extract, we find precise details of how to elicit the physical sign of 'inability to shed tears'. The sign of inability to shed tears, moreover, is, in the terms of modern scientific classifications, both reliable (shown by 'worthy men of old and our own experience') and has construct validity (it is caused by the Devil's preventing penitential tears). Of course, as skilled examiners we must beware of malingering (she may smear her face with spittle) and false positives (she may deceive us with her witchery into seeing tears). But these risks can be minimized by repeated examination in different ways (p. 213, also pp. 230–231), and, later in this section, by taking sensible precautions such as avoiding her glance (p. 228), and by following correct procedure (not allowing her to return to her room after she has been apprehended, p. 215). All very 'modern', then, the last in particular strongly reminiscent of 'child abuse' procedures. And if we doubt the effectiveness of all these diagnostic procedures, well Kramer and Sprenger go on to offer us ample supporting case histories (e.g. p. 229).

Values and science

The point of drawing these parallels is not to suggest that demonology is on a par with biology. Many have claimed that *all* knowledge is relative: as we will see in Part III, as a modern form of radical scepticism, this (self-defeating) assertion has been highly influential in some quarters in recent philosophy of science. But the point for us, here, is that science itself, far from guaranteeing objectivity, may give authority to current bias and prejudice.

EXERCISE 6 (20 minutes)

- Does all this remind you of anything in the recent history of the abuse of psychiatry?
- Can you think of an example of a situation in which a similar conjunction of ideology and science led to grossly abusive uses of medical psychiatry?

As you think about this, read a final extract from the *Malleus Maleficarum*:

Kramer, H and Sprenger, J. (1996). Malleus Maleficarum (The Witch Hammer). Published as Malleus Maleficarum: *the*

Classic Study of Witchcraft, translated with an introduction, bibliography, and notes, by Montague Summers. London: Bracken Books, pp. 1–3

Link with Reading 7.6

In this extract (pp. 1–3) of the *Malleus Maleficarum*, Kramer and Sprenger set out the theoretical foundations on which their treatment of witchcraft is built. The 'bias and prejudice' is clear. They recite alternative theories, current at the time, notably that 'there is no such thing as magic, that it only exists in the imagination . . .', but they roundly reject such theories as heretical: they are, they say, contrary to 'the authority of the Holy Scripture', and 'the true faith'. Of course, they continue, it is true that magic is sometimes 'merely in the imagination'. But given the overwhelming authority of the Scripture, the Saints, the Canons, and so on, 'those who suppose that *all* the effects of witchcraft are mere illusion and imagination are very greatly deceived' (p. 3, emphasis added).

The driving force, then, behind everything that follows in the *Malleus Maleficarum*, is dogmatic religious ideology. The witch trials of this period thus had the same ingredients as, in recent history, the institutionalized abuse of psychiatry in the final years of the former USSR. We return to this in Part IV (Chapter 18). There are many differences, of course. But in both cases, as we will see, the dominant power group (the communists in the USSR, the Catholics or Protestants in Reformation Europe) needed some way of reinforcing their own value system and beliefs. In both cases, they sought the authority of science to support their persecution of dissenters (in Reformation Europe, medical experts 'proved' that dissenters were witches; in the Soviet Union, they 'proved' that dissenters were insane). In both cases, then, science was harnessed to a value system that made a virtue of suppressing dissent.

We should not be too ready to scoff at Kramer and Sprenger, however. As we will see in Chapter 11, recent work in the history and philosophy of science has shown the extent to which science remains authority led, in its overall theories, and in the extent to which aberrant experimental results are interpreted to fit those theories. There is not an argument for radical scepticism. As the Italian historian and philosopher of science, Paolo Rossi, has argued, the achievements of the Renaissance, '. . . logical rigour, experimental control, the public character of results and methods . . .' were hard won at the time and, even today, have to be continually defended (Rossi, 2003, p. 263). Science as such is no sinecure against bias and the *vox populae*!

The Great Confinement

By the end of the seventeenth century, naturalistic theories of madness had once again become the dominant paradigm, science had largely triumphed over Satan, and a more humanistic approach to the care of people with mental disorders began to emerge. Sporadic public provision had been available since the Middle Ages. But parishes were now made responsible for their mentally disordered members. They responded to this by 'boarding' them out. A large number of private 'madhouses' were thus established, marking the start of what Michel Foucault (1989) called 'the great confinement'. Foucault based his view of the history of this period on the Hôpital Général in Paris. But large public asylums only became widespread in the UK during the nineteenth century, notably after the Lunatics Act of 1845 made it compulsory for every county to establish such institutions. All the same, it is true that there was a progressive shift from 'community care' to confinement; and that the number of people confined rose dramatically through the eighteenth and into the nineteenth centuries.

Many 'madhouses', private and public, sought to offer some form of treatment within a humane environment. Most had either retained physicians or physician-superintendents. Treatment, however, usually took the form of restraint, often with shackles or straightjackets, combined with punitive procedures such as ducking. There were, moreover, many unscrupulous profiteers in the 'trade in madness', a trade made the more profitable by the fact that resources rapidly became wholly inadequate to the rising tide of new admissions. There were also, however, many who stood for a more humanitarian approach. By the end of the century, a Quaker, William Tuke, had established The Retreat at York in England, offering 'moral therapy' based on a homely environment; and in Paris, Phillipe Pinel, and his pupil Jean Etienne Dominique Esquirol, had 'thrown away the chains' of the patients in the Salpêtrière and Bicêtre Hospitals.

Fig. 7.4 Philippe Pinel

It is difficult to get a balanced view of the treatment of those with mental disorders over this period. The common perception is famously reflected in the contemporary painting by the eighteenth century Dutch—English painter (and cartoonist), Hogarth, called, simply, 'Bedlam'. Modern scholarship has shown, however, that, although abuses were common enough, conditions in private institutions were more often humane by the standards of the day; and the public asylum movement was launched in a spirit of genuine therapeutic optimism. Such misportrayals of 'madness' are common today. Hogarth's picture is an eighteenth century counterpart of Ken Kesey's famous book (and later a film) *One Flew over the Cuckoo's Nest* (1963)!

Complementary approaches to the social history of madness over this period, relevant to contemporary psychiatry, are illustrated by Roy Porter's, *A Social History of Madness* (1987), and William Parry-Jones's *The Trade in Lunacy* (1972). Roy Porter was Professor of History of Medicine at the Wellcome Institute in London. William Parry-Jones was a psychiatrist who won the Year Prize at Cambridge for an MD in the history of medicine on which his book is based. Both explore madness in the eighteenth century. Porter employs much narrative material from accounts of contemporary 'survivors'. Parry-Jones draws particularly on detailed historical analyses of contemporary statistical and other records. Both, in different ways, give us a picture that is far from the 'Hogarthian Bedlam'. Yet both have important messages from the period for modern psychiatry: the dangers of 'graft' and false confinement; the difficult yet crucial balance between care and control; the importance of adequate checks and balances external to the interests of professionals, however well intentioned; the failure of reforms if they are inadequately resourced, and so on.

By the middle of the nineteenth century, then, large numbers of mentally ill patients had been confined mainly under the supervision of medical superintendents. With scientific medical knowledge advancing rapidly, the stage was thus set for the emergence of a recognizably medical psychiatry.

Psychiatry's two biological phases

Psychiatry's first biological phase

Although 'medical' theories of insanity had been around since Hippocrates, it is only in the second half of the nineteenth century, and notably in Germany, that modern causal theories start to appear. There had been important work in descriptive psychopathology in France in the first half of the century. However, the father of biological psychiatry is generally identified as William Griesinger, who, in the 1860s from his position as Professor of Psychiatry at the University of Berlin, coined the uncompromising aphorism that 'Mental illness is cerebral illness' ('Geisteskrankheiten sind Gehirnkrankheiten'—quoted by Jaspers *Allgemeine Psychopathology*, p. 382; *General Psychopathologie*, p. 459).

This was a period of optimistic expansion. Pioneers were opening university clinics of psychiatry in Germany for the first time and appointing professors. The race was on to find the brain abnormalities that lay at the basis of the major psychoses. There were many successes, although more in the field of neurology than psychiatry. Thus, Carl Wernicke, working in Vienna and Berlin, demonstrated an association between patients who could not understand speech and an abnormality in the posterior temporal lobe of the brain. This is still called Wernicke's area. In France, Paul Broca found an association between patients who could understand what was said to them but could not express themselves, and an abnormality in the posterior frontal lobe. This is still called Broca's area.

Next to Griesinger, Theodor Meynert, Professor of Psychiatry in Vienna, was perhaps the most famous representative of psychiatry's first biological phase. Meynert was to be a tutor to Sigmund Freud (he was also a chronic alcoholic). Meynert has no lasting findings to his credit but he did establish the importance of neurohistology for research into the major psychoses. Meanwhile, in the 1880s, Paul Flechsig, in Leipzig, was creating a map of brain areas responsible for different psychological functions, and Eduard Hitzig, in Halle, was demonstrating that the brain responds to electrical stimulation.

The 'action', then, in the late nineteenth century, was mainly in neurology, which at the time was not sharply distinct from psychiatry. Two disorders, however, were to emerge from this period that are of particular importance for psychiatry—Alzheimer's disease and general paralysis.

Mental illness and brain disorder

We owe the identification of these two disorders to Alois Alzheimer and Franz Nissl. They were great friends. Alzheimer was working in Frankfurt and Nissl in Heidelberg (where he was to become Jaspers' professor). Nissl had developed stains that allowed nerve cell structures to be seen. Together, Alzheimer and Nissl worked on brain histology. Alzheimer described the brain changes in the disease, mostly of senility, which has come to bear his name, and, together, they described the brain changes in general paralysis, a disease that had been rife since the major wars in Europe.

There had been enormous speculation about the cause of general paralysis and whether it had its origins in earlier syphilitic infection. Henry Maudsley, who was later to give his name to the modern descendant of the 'Bedlam' hospital (the Maudsley and Bethlem Hospital in London), believed it was not syphilitic, but events were to prove him wrong. Alzheimer and Nissl showed that general paralysis had a different brain histology to Alzheimer's disease. Then in 1906, Wasserman invented the test that bears his name and showed that patients suffering from general paralysis tested positive for syphilis. Finally, in 1913 Noguchi and Moore demonstrated the existence of *Treponema pallidum* (the bacillus responsible for syphilis) in brain tissue. This was a world-changing event. For the first time, a specific psychiatric disease had been shown to have a specific neuropathological cause. The search for the specific brain causes of the major psychoses was reinvigorated and continues to this day, though with, as yet, little more to show!

Fig. 7.5 Alois Alzheimer

Fig. 7.6 Emil Kraepelin

It is important for our understanding of contemporary psychiatry to note that even in psychiatry's first biological phase, 'moral' theories of madness continued to be influential. This was notably so even in Germany, with the 'Romantic Psychiatry' movement. Recent scholarship, moreover, has shown the extent to which Griesinger himself, the 'father' of biological psychiatry, had a sophisticated understanding of the complexities involved in a genuinely biological psychiatry.

This is vividly illustrated by the philosopher and German scholar Katherine Arens' article in *Philosophy, Psychiatry, & Psychology* on *Wilhelm Griesinger* (1996, 147–164), and the commentary by North American philosopher and psychologist, Aaron Mishara (1996, pp. 165–168). Arens' article gives a sense of the excitement of the dramatic 'new wave' of biological thinking in German psychiatry in the second half of the nineteenth century. It is also an example of how careful scholarship, equipped with philosophical and historical skills, can help us to understand the work of key historical figures in a way which is highly relevant to contemporary problems. It is crucial, in giving balance to the current biological approach to psychiatry, to recognize that its own heroes were acutely aware of the limitations, as well as the strengths, of a brain-based approach to mental disorder. Mishara effectively underscores this point by relating Griesinger's thinking directly to the currently renewed interest in hermeneutics and the importance of phenomenology as a partner to neuroscience in the new biology of psychiatry.

Kraepelin and psychiatric classification

Consistently with the proliferation of theories of the causes of mental disorder in the second half of the nineteenth century, there was a proliferation of classifications. As R.E. Kendell put it in his *The Role of Diagnosis in Psychiatry* (1975), this was a period when every professor of psychiatry had his own system. It was Emil Kraepelin, a gifted physician and scientist, who, through a series of editions of his *Lehrbuch* (textbook (1915)), started to bring order out of chaos.

Kraepelin arrived in Heidelberg in 1890 and set about collecting around him a formidable range of the major figures in neuropsychiatry of the time, including his friend Nissl (in 1895). Kraepelin had earlier studied brain histology under Paul Flechsig in Leipzig. But he had an eye problem and had difficulty with microscopes. Not surprisingly, perhaps, he got on badly with Flechsig and left. (There is a story that he was sacked.) His career was rescued by the eminent experimental psychologist, Wilhelm Wundt, founder of the first psychological laboratory and the first journal of experimental psychology. Wundt was attempting to build an experimental psychology on the paradigm of the natural sciences—an experimental introspectionism—and Kraepelin was to carry over what he had learned from Wundt into psychiatry.

It was in part because of his problems with microscopes that Kraepelin focussed on clinical research. He kept meticulous records (in the form of cards) on the symptomatology and clinical course of his patients. It was this careful clinical work that came to fruition in his *Lehrbuch*. In the face of the neuroresearch around him, Kraepelin made major advances in the clinical description of psychiatric disorders. His work was not without its problems. Many of the cases he had diagnosed clinically as general paralysis proved not to have syphilis. But he gave us the basis of the psychiatric classification that is still in use today—in particular, the distinction between dementia praecox and manic depressive illness. (The term 'dementia praecox' was changed to 'schizophrenia' by Eugen Bleuler in 1912.)

Patients, brains, and persons

With the notable exception of Kraepelin, German academic psychiatry in the late nineteenth century was dominated by brain scientists trying unsuccessfully to find the neuropathological basis of the major psychoses. Most were uninterested in patients and clinically naïve, a characteristic that was very much resented by the asylum psychiatrists who had responsibility for the patients. (An early round in the ongoing dog fight between clinicians and researchers!) Paul Flechsig had to be sent away on a sabbatical to learn psychiatry prior to taking up his chair. Franz Nissl, even at the time he had become Jaspers' professor in Heidelberg, was said to carry Kraepelin's textbook in his white coat pocket for quick reference on ward rounds! One of Meynert's junior physicians, Arnold Schitzler (who was later to become a playwright), wrote of him:

> He was a great scholar, a splendid diagnostician, but as a physician in the narrower sense, in his personal relations with patients, . . . he did not win my admiration. As masterful as he may have been in the face of disease, in front of the sick person his behaviour often seemed to me cool, uncertain, if not indeed anxious. Quoted in Shorter (1997, p. 77)

Karl Jaspers and biological psychiatry

It was in this atmosphere of reliance on brain science, that Karl Jaspers began his work. He started as a junior psychiatrist in Nissl's department in Heidelberg in 1908. This was a time of therapeutic pessimism. Despite the rapid advances in neuropathology, very little in the way of treatment was available. All the clinician could do was await spontaneous improvement or not. In 1911, Jaspers was commissioned by Nissl to write a textbook of psychopathology. The first edition of *Allgemeine Psychopathologie* (*General Psychopathology*) appeared in 1913. Jaspers intended this as a methodological and philosophical overview of the subject, examining the nature and possibility of knowledge in psychiatry. Jaspers recognized the importance of natural scientific techniques in psychopathology. He was well aware of Kraepelin's system of classification, of the neuropathological advances in Alzheimer's disease, and of the recently demonstrated syphilitic aetiology of general paralysis. However, he considered that the passion for brain research had gone too far: 'These anatomical constructions, however, became quite fantastic (e.g. Meynert, Wernicke) and have rightly been called "Brain Mythologies" (Jaspers, [1913] 1963/1997 *General Psychopathology,* p. 18)'.

As we will see in more detail in Chapter 8, Jaspers thus came to emphasize the need for meaningful as well as causal explanations in psychiatry. In medical psychiatry, it is the 'causal' side of his work that has been most influential as his psychopathology has come to form the basis of modern 'scientific' approaches to psychiatric diagnosis. But in the meantime, even as Jaspers was developing his psychopathology, competitors to biological psychiatry were already emerging.

Competing paradigms: psychological

By the late 1920s, psychiatry's first biological phase was drawing to a close, not least because of the poverty of findings. The neuropathological causes of the major psychoses had not been found. The field, therefore, was clear for alternative theories.

One such theory, building on earlier associationist psychologies, was based on the Russian psychologist, Ivan P. Pavlov's, concept of the conditioned reflex. Pavlov, as is well known, developed a detailed 'learning theory' based on the observation (familiar to animal trainers) that dogs could be conditioned to salivate to the sound of a bell ringing by associating it with food. (Salivating to the food is an unconditioned reflex, salivating to the bell is the conditioned reflex.) Among other important findings, Pavlov showed that neurotic behaviour could be induced in his dogs if they were exposed to incompatible stimuli (e.g. pain and food), or to inconsistent conditioning.

Pavlov's theories were influential in Russia; other forms of 'learning theory' were developed later in the century (notably by J.B. Watson and B.F. Skinner in the USA); and learning theory approaches (though not specifically Pavlovian approaches) to treating some forms of mental disorder have become highly influential and important in modern psychiatry and clinical psychology (see, e.g. Hawton *et al*., 1989). Over much of this century, though, even more influential has been psychoanalysis, developed originally by the Austrian neurologist, Sigmund Freud.

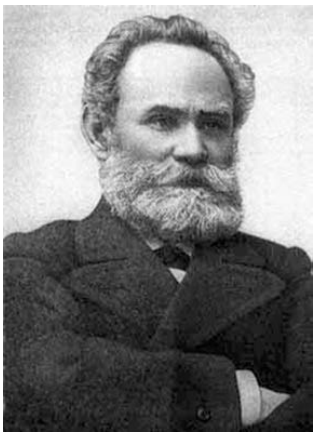

Fig. 7.7 Ivan Pavlov

Freud and the psychoanalytic movement

Freud, although trained as a neuroscientist, was impressed by the therapeutic power of suggestion, notably in Charcot's work on hysteria at the Salpêtrière in Paris; and by Pierre Janet's demonstration of the recovery of lost traumatic memories. This inspired his central (clinical) insight that aberrant experience and behaviour could be an expression of conflicting mental contents (wishes, desires, beliefs, etc.) of which we are unaware (i.e. they are unconscious). Psychoanalysis split early on into a number of movements, Jungian, Adlerian, etc. This has not been to the credit of psychoanalysis, or, indeed, to psychiatry. In the public image, and perhaps in reality, conflicting, rather than competing, paradigms have been characteristic of twentieth century psychiatry.

Psychoanalysis became (and has remained) highly influential in France. But it was in the USA that it reached its zenith. Paradoxically, a major factor in the promotion of psychoanalysis was the rise to power of the Nazis in Germany in the 1930s. The antisemitism of the regime forced the emigration of Freud and his disciples, almost all of whom were Jewish—Freud to London and most of the rest to the USA. Even before this, psychoanalysis had found favour with the private practice/office-based psychiatry of the time in the USA. Many psychoanalysts, including Jung, Ferenzi, Jones, and Freud himself, had visited the USA to give lectures. The first psychoanalytic society was founded by Henry Brill in New York in 1911. The German psychoanalysts moving to the USA included some very 'big names'—Franz Alexander to Chicago, Sando Rado to New York, and Otto Fenichel to Los Angeles. The influx created some notable linguistic problems. In a lecture at the Menninger Clinic, Fenichel wanted to talk about 'penis envy', but was having problems with the translation. Fenichel tried 'penis envoy' and another émigré suggested 'penis ivy' (reported by Shorter, 1997, p. 167).

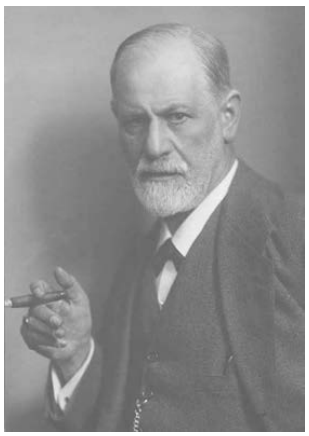

Fig. 7.8 Sigmund Freud

Psychoanalysis has had a rather chequered relationship with medicine. In the UK, the two disciplines have developed rather separately. In the States, at least until recently, they were closely related. By 1938, the American Psychoanalytic Association dictated that all candidates for a training analysis must have completed at least 1 year of residency in psychiatry. By the early 1940s, American psychiatry was firmly tied to psychoanalysis and vice versa. Psychoanalysis in the USA boomed until the early 1980s, since when it has gone into steep decline with the rise of a new phase of biological psychiatry. Current views on the status of psychoanalysis are sharply divided. As we will see in Chapter 11, many doubt its scientific credentials. Jaspers, for one, firmly rejected it. He considered psychoanalysis to be a perversion of his method of understanding (*Verstehen*): 'In this way within the confines of psychopathology there grew a methodological comprehension of something which had always been present, but which was fading out of existence and which appeared in striking reverse, "through the looking-glass" as it were in Freud's psychoanalysis—a misunderstanding of itself.' (Jaspers, [1913] 1997, *General Psychopathology*, p. 302).

The second biological phase

The first biological phase was founded on brain pathology, reflecting Griesinger's aphorism 'mental illnesses are brain illnesses'. The second biological phase, although now building on genetics and brain-imaging techniques, started with psychopharmacology and the move from neuroanatomy to neurochemistry as the likely locus of abnormality in the major psychoses.

Modern psychopharmacology of the major psychoses began in the 1950s with the development of such drugs as lithium for hypomania, chlorpromazine for schizophrenia and imipramine for depression. We now know some of the actions of these drugs in the brain. The inference is usually drawn that if a drug acts on a particular system then there must have been something wrong with that system to make the patient ill. Take schizophrenia. The drugs that are effective in schizophrenia all block the neurotransmitter dopamine (a neurotransmitter is a chemical that transmits signals between nerve cells). Therefore, many conclude, there must be an overactivity of brain dopamine in schizophrenia. As an inference, of course, this is not strictly justified. (We looked at inferences of different kinds in Chapter 5.) Moreover, despite considerable effort, the requisite overactivity has not been identified. But as a *hypothesis*, the dopamine theory is entirely reasonable. And it has been the power of the new drugs to alter experience and behaviour, which has kick-started the new wave of biological psychiatry as we head into the twenty-first century.

Reflection on the session and self-test questions

Write down your own reflections on the materials in this session drawing out any points that are particularly significant for you. Then write brief notes about the following:

1. Who represented moral and natural conceptions of madness, respectively, in classical Greek and Roman thought?
2. In which cultures were moral and natural conceptions of madness, respectively, dominant in the early Mediaeval period?
3. With what attitudes to madness were the Renaissance and Reformation associated?
4. How did things change in the Enlightenment?
5. What was the Great Confinement? When did it happen?
6. What was Karl Jaspers' work as a philosopher-psychiatrist a response to?
7. How is Jaspers' work similar to recent developments in the philosophy of psychiatry?

Conclusions: possible futures

The lesson(s) of history

In this chapter, we have looked at a variety of readings, which, although broadly in the area of the history of psychiatry, are very different in nature, form, and style. Each of these illuminates, in different ways, our understanding of psychiatry, and in particular of the theoretical and practical difficulties surrounding the concept of mental illness. But is there an overall direction, an overall trend in this history, pointing us unequivocally to a particular future?

EXERCISE 7 (30 minutes)

In this final exercise, we look at two 'overviews' of the history of psychiatry:

1. A brief extract from the epilogue to a now classic study:

   Zilboorg, G. and Henry, G.W. (1941). The second psychiatric revolution. In *A History of Medical Psychology*. London: George Allen and Unwin, (Extract p. 522–523.)

2. A brief extract from the concluding pages of:

   Shorter, E. (1997). *A History of Psychiatry: from the era of the asylum to the age of prozac*. New York: John Wiley and Sons. (Extract p. 325.)

Link with Readings 7.7 and 7.8

- What do you see as the main differences between these two overviews of the history of psychiatry?

Note: the 'Brill' referred to in the first reading is A.A. Brill, one of Freud's pupils who introduced psychoanalysis to America.

These two readings represent two very different overviews of the history of psychiatry. With Zilboorg and Henry, writing in the 1940s, when psychoanalysis was 'all the rage', at least in America and France, Freud was perceived as having rescued a genuinely human psychiatry from the one-sided brain-based approaches of the turn of the twentieth century. By the 1990s, however, Shorter sees the psychoanalytic movement as little more than a distraction from the serious business of biological psychiatry.

Both perspectives are illuminating. Zilboorg and Henry help us to see, especially in the current wave of anti-Freudianism, the clinical importance of the psychoanalytic movement. Shorter gives us marvellous insights into the subversion of biological psychiatry by greed and graft! Neither book, moreover, is naïve as to the perspectives of history: Zilboorg and Henry anticipate that attitudes to Freud may change; Shorter explicitly acknowledges the difficulties of historical interpretation. But both are *basically* convinced that their overview is right. Shorter adopts an engaging contrast between postmodern historians of psychiatry and himself: '*they*' (the postmodernists) are 'revisionists', *he* is a 'neoapologist'! (p. ix).

So, as noted in the introduction to this part of the book, we need to be cautious in projecting forward from history. History does have lessons for us, as we have seen. But, to adapt a familiar aphorism, history never *quite* repeats itself. There are always differences as well as similarities between historical periods, and the differences can be important.

Biologies old and new

One difference between the first biological phase and the second, is the importance, today, of psychological and social methods of treatment alongside physical. *Clinical* psychiatry is nowadays openly eclectic: it is the 'biopsychosocial' approach which is *de rigeur* (McHugh and Slavney, 1983).

A second difference is the importance of descriptive psychopathology. Like general medicine, developments in the neurosciences relevant to psychiatry are building on careful clinical observation of the actual phenomena of mental disorders. As we have seen, we owe the broad outlines of our classification of mental disorders to the careful work of Kraepelin and others at the turn of the twentieth century. But the descriptive psychopathology from which modern descendants of these classifications are constructed, we owe mainly to Karl Jaspers. It is to a more detailed study of Jaspers, then, and the conceptual structure of his descriptive psychopathology, that we turn in the next chapter, chapter 8.

A third difference, and one to which we owe the very existence of this book, is the extent of developments in the philosophy of psychiatry. In psychiatry's first biological phase, as we will see, Karl Jaspers, as a philosopher and psychiatrist, was a central but somewhat isolated figure. In psychiatry's second biological phase, by contrast, as Fulford *et al*. (2003) describe, a whole discipline of philosophy and psychiatry has sprung up around the world. The 1990s was indeed the decade of the brain. But it was also the decade of the mind (Fulford *et al*., 2003). Exploring, therefore, as we will in the remaining chapters of this part, the details

of Jaspers' psychopathology (chapter 8), and its intellectual origins respectively in phenomenology (chapter 9) and the *method-enstreit* (chapter 10), will help to define the new challenges for psychopathology today, a psychopathology that is informed, equally, by the empirical findings of the new neurosciences and by the conceptual insights of the new philosophy of psychiatry.

Reading guide

The history of psychiatry and psychopathology

Although until recently relatively neglected by historians of medicine, the history of psychiatry is now an actively developing discipline.

Outlines of the history of psychiatry will be found in most larger psychiatric textbooks. W.F. Bynam's (1983) chapter, for example, 'Psychiatry in its historical context', offers a highly readable detailed overview. A classic text is G. Zilboorg and G.W. Henry (1941) *A History of Medical Psychology*. Recent years have seen an abundance of new histories. Some of these, like E. Shorter's (1997) *A History of Psychiatry* have a particular story to tell.

Excellent introductions to the histories of all the main areas of psychopathology, are G.E. Berrios' (1996) *The History of Mental Symptoms*, and G.E. Berrios and R. Porter (ed.) (1995) *A History of Clinical Psychiatry*. Beer's (1996) *The Dichotomies* charts the shift in our understanding of psychosis from mental disorder to disease concept.

Perhaps the most acute historian of twentieth century psychiatry is the French historian and psychiatrist, George Lanteri-Laura (eg 1998). The history of British psychiatry has been surveyed in Richard Hunter and Ida McAlpine's (1963) *Three Hundred Years of Psychiatry: 1535–1860*; and Berrios and Freeman's (ed.) (1991) *150 Years of British Psychiatry: 1841–1991*.

The American psychiatrist and historian, Jerome Kroll (1995), has explored the issues raised by historical work on concepts of disorder in a review article in *Philosophy, Psychiatry, & Psychology* on 'The historiography of the history of psychiatry'. See also his historical work on spiritual experience and psychosis (Kroll and DeGanck, 1986, and Kroll and Bachrach, 2005).

History of the concept of mental disorder

Daniel Robinson's (1996) *Wild Beasts and Idle Humours*, from which the reading for Exercise 4 in this chapter was taken, is particularly helpful as a *conceptual* history of psychiatry because of its focus on the 'insanity defence'. A remarkable *tour-de-force* of two and a half millennia of psychiatric history, each chapter combines encyclopaedic scholarship with a lively style to bring to life the ways in which mental distress and disorder were understood at each of the main periods of the history of psychiatry. Paul Hoff's (2005) article (in German) explores the tendency of psychiatry at different periods to fall back on one or another dominant model.

Eighteenth and nineteenth centuries

The history of psychiatry in the eighteenth and nineteenth centuries, has been one of the battlegrounds of the psychiatry/antipsychiatry debate. As we saw in Part I, the French psychologist-philosopher, Michel Foucault (1989), in his *Madness and Civilisation*, argued that the concept of 'mental illness' emerged in parallel with the Great Confinement of the late eighteenth and nineteenth centuries, as a response to the needs of the work-ethic of the Industrial Revolution. Roy Porter (1987; whose richly detailed *A Social History of Madness*, we looked at in this chapter) is among those who, although in the past identified with antipsychiatry, has offered a more balanced understanding of this period: see, for example, his (1985) *The Anatomy of Madness* (2 vols) jointly authored with one of the 'hard men' of psychiatric science, Michael Shepherd. The article by Katherine Arens (1996) in *Philosophy, Psychiatry, & Psychology* on 'Wilhelm Griesinger: psychiatry between philosophy and praxis', and the commentary by Aaron Mishara (1996) suggest, similarly, that we may need to reappraise the received views about the 'birth of biological psychiatry' in the second half of the nineteenth century. As we also saw in this chapter, the historian-psychiatrist, William Parry-Jones' (1972) *The Trade in Lunacy* is a model of careful and scholarly research in this difficult area. But that the battle continues is illustrated by an exchange in *The History of Psychiatry*, between the psychiatrist-historian John Crammer and one of the historical gad-flies of psychiatry, Andrew Scull (see Crammer, 1994, and Scull, 1995).

Other periods

Other periods have also attracted recent research. We looked at Lennart Nordenfelt's (1997a) work on the Stoics in this chapter, in his 'The stoic conception of mental disorder: the case of Cicero', with commentaries by Blackburn (1997), Leavy (1997), Mordini (1997), and Rhodes (1997); and Nordenfelt's response (1997b); and the earlier work of A.J.P. Kenny (1969) 'Mental health in Plato's Republic'. A further example is the New Zealand philosopher, Andrew Moore's, study of Aristotelian 'eudaimonia' and the concept of hypomanic mood disorder in Moore *et al.*'s (1994) 'Mild mania and well-being'; with commentaries by L. Nordenfelt, 1994 and D. Seedhouse, 1994. Recently renewed interest in the importance of classical work for ethics, for example in Bernard Williams' (1985) *Ethics and the Limits of Philosophy*, and Michael Stocker's (1997) 'Aristotelian akrasia and psychoanalytic regression' (with a commentary by P.G. Sturdee, 1997); and the paper by the philosopher, Chris Megone (1998) 'Aristotle's function argument' (with commentaries by Szasz (1998), Hobbs (1998) and Fulford (1998) and a response (Megone, 1998b), and a further special issue of *Philosophy, Psychiatry, & Psychology* on 'Aristotle, function and mental disorder' (Sadler and Fulford, 2000a and 2000b), with contributions by Szasz (2000), Wakefield (2000), Megone (2000), Thornton (2000), and Fulford (2000), all show the classical period to be

a potentially fertile field for cross-disciplinary work between history, philosophy, and psychiatry.

An important focus of work on mediaeval conceptions of madness has been the relationship between spiritual experience and psychopathology: the American historian and psychiatrist, Jerome Kroll's. Kroll has also contributed importantly to the philosophical debate, see in particular, Roth, M. and Kroll, G. (1986) *The Reality of Mental Illness*, written as a direct reply to Thomas Szasz's claim that mental illness is a myth.

Coming right up to date, we will see in later chapters (for example, in Chapter 13 on psychiatric classification), that the modern history of psychiatry has important lessons for the development not only of policy and practice but of the research base of the discipline. A recent translation, for example, by Sula Wolff (2000) of a study of abnormal happiness by one of the founders of modern descriptive psychopathology, William Mayer-Gross, has, as the two commentators on the translation by Dominic Beer (2000) and Sir Martin Roth (2000) showed, potentially important implications for the direction of current research into the understanding and classification of disorders of mood.

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